SERFF Tracking Number:	*USHG-127096386*	*State:*	*Arkansas*
Filing Company:	*Freedom Life Insurance Company of America*	*State Tracking Number:*	*48334*
Company Tracking Number:	*ACCDIS-2011-C-NOARB-FLIC*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*ACCDIS-2011-C-NOARB-FLIC*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Freedom Life Insurance Company of America

Product Name: ACCDIS-2011-C-NOARB-FLIC	SERFF Tr Num: USHG-127096386	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 48334
Sub-TOI: H11G.002 Short Term	Co Tr Num: ACCDIS-2011-C-NOARB-FLIC	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Shelley Rooker, Shannon Morgan Cubby	Disposition Date: 03/29/2011
	Date Submitted: 03/24/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Association	Overall Rate Impact:
Filing Status Changed: 03/29/2011	
State Status Changed: 03/29/2011	Deemer Date:
Created By: Shelley Rooker	Submitted By: Shelley Rooker

Corresponding Filing Tracking Number:

Filing Description:

See attached cover letter.

Company and Contact

Filing Contact Information

Shannon M. Morgan, Product Analyst	morgans@ushealthgroup.com
3100 Burnett Plaza	817-878-3748 [Phone]

SERFF Tracking Number:	*USHG-127096386*	*State:*	*Arkansas*
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Product Name:	*ACCDIS-2011-C-NOARB-FLIC*		
Project Name/Number:	*/*		

801 Cherry Street, Unit 33
Fort Worth, TX 76102

817-878-3310 [FAX]

Filing Company Information

Freedom Life Insurance Company of America	CoCode: 62324	State of Domicile: Texas
3100 Burnett Plaza	Group Code: 839	Company Type: Accident, Life and Health
801 Cherry Street, Unit 33	Group Name:	State ID Number:
Fort Worth, TX 76102	FEIN Number: 61-1096685	
(817) 878-3328 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	$100.00 per filing
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Freedom Life Insurance Company of America	$100.00	03/24/2011	45942178

SERFF Tracking Number:	*USHG-127096386*	*State:*	*Arkansas*
Filing Company:	*Freedom Life Insurance Company of America*	*State Tracking Number:*	*48334*
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Product Name:	*ACCDIS-2011-C-NOARB-FLIC*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/29/2011	03/29/2011

SERFF Tracking Number:	*USHG-127096386*	*State:*	*Arkansas*
Filing Company:	*Freedom Life Insurance Company of America*	*State Tracking Number:*	*48334*
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Product Name:	*ACCDIS-2011-C-NOARB-FLIC*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 03/29/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*USHG-127096386*	*State:*	*Arkansas*
Filing Company:	*Freedom Life Insurance Company of America*	*State Tracking Number:*	*48334*
Company Tracking Number:	*ACCDIS-2011-C-NOARB-FLIC*		
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Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover letter	Approved-Closed	Yes
Form	Association Group Short Term Accident Disability Income Certificate	Approved-Closed	Yes

SERFF Tracking Number:	*USHG-127096386*	*State:*	*Arkansas*
Filing Company:	*Freedom Life Insurance Company of America*	*State Tracking Number:*	*48334*
Company Tracking Number:	*ACCDIS-2011-C-NOARB-FLIC*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*ACCDIS-2011-C-NOARB-FLIC*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: ACCDIS-2011-C-NOARB-FLIC

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/29/2011	ACCDIS-2011-C-NOARB-FLIC	Certificate	Association Group Short Term Accident Disability Income Certificate	Initial			ACCDIS-2011-C-NOARB-FLIC.pdf

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102 • 1-800-387-9027]

ASSOCIATION GROUP SHORT TERM ACCIDENT DISABILITY INCOME INSURANCE CERTIFICATE

This is Your **Certificate** under the **Group Short Term Accident Disability Income Insurance Policy** issued to the association that is the **Group Policyholder** and in which association the **Insured** is an enrolled member**.** This coverage is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Certificate.** Certain phrases and words contained in this **Certificate** have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS. This **Certificate** is a legal contract between each **Insured** and the **Company.** Please read it carefully!

Your Certificate is guaranteed renewable to age 68, subject to the **Company's** right to adjust **Renewal Premiums** in accordance with Section IV. B. RENEWAL PREMIUM, and otherwise discontinue or terminate the **Certificate** as provided in Section III. C. TERMINATION OF COVERAGE. The **Initial Premium** for coverage under this **Certificate** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the Section IV. B. RENEWAL PREMIUM. **You** may renew coverage under this **Certificate**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to this **Certificate**, to see if any medical history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or an **Insured's** coverage to be reformed or voided.

The **Certificate** was issued in consideration of (i) the payment of the **Initial Premium**, (ii) upon **Our** reliance upon **Your** representation that the answers to all questions in the application are correct and complete, and (iii) upon **Our** reliance upon the representation from **You** that the content of any supplemental information provided to **Us** in the underwriting process, including information provided during any telephone verification of the application or by e-mails, facsimiles and correspondence is in each instance correct and complete.

YOUR [10 - 30] DAY RIGHT TO RETURN THIS POLICY

If **You** are not satisfied with **Your** coverage, **You** may return this **Certificate** to **Us** within [ten (10)-thirty (30)] days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. **Your** coverage will be voided as of the **Issue Date**, and **We** will refund any premium **We** have received prior to **Our** receipt of the returned **Certificate**.

SECRETARY

PRESIDENT

THIS IS A SHORT TERM ACCIDENT-DISABILITY INCOME CERTIFICATE.
IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS.
THIS CERTIFICATE PROVIDES ONLY ASSOCIATION SHORT TERM ACCIDENT-DISABILITY INCOME INSURANCE COVERAGE.

TABLE OF CONTENTS

I. CERTIFICATE SCHEDULE

A. GENERAL INFORMATION

Coverage is pursuant to a **Group Short Term Accident-Disability Income Insurance Policy**

Issued to Group Policyholder: [ ]

Certificate form: [ACCDIS-2011-C-FLIC]

Primary Insured: [ ] Age at Issue: [ ]

Certificate Number: [ ] **Issue Date**: [ ]

Initial Premium:

Amount	**Mode Of Premium Payment**	**Method**
$[ ]	[Monthly, Quarterly, Semi-Annual, Annual]	[Credit Card, Check]

First Renewal Date: [ ]

First Renewal Premium	**Mode Of Premium Payment**	**Method**
$[ ]	[Monthly, Quarterly, Semi-Annual, Annual]	[Bank Draft]

B. COVERAGE SCHEDULES

[Elimination Period]	[[14][30] days]
Monthly Total Disability Benefits	[$500, $1,000, $1,500]
Maximum Period Payable for each Period of Total Disability	[3, 6, 124] months

II. DEFINITIONS

"Accident," "Accidentally" means an event or occurrence that was unplanned and unintended by the **Insured** that was the sole cause of **Injuries** sustained or suffered by such **Insured** and that takes place on or after the **Issue Date**.

"Actively at Work" means **You** are (i) working on a permanent basis at least [twenty-five (25)-forty (40)] hours per week; and (ii) performing the material and substantial duties of **Your** regular job [or any other job for which **You** are qualified by reason of education, training or experience].

"Benefit(s)" means the coverage specifically set forth in the **Certificate Schedule**, and otherwise described in Section V. SHORT TERM ACCIDENT DISABILITY INCOME BENEFIT.

"Calendar Year" means the period beginning on the **Issue Date** and ending on December 31 of that year. In subsequent years, it is the period from January 1 through December 31 of the same year.

"Certificate" means this contract of coverage between all **Insureds** and the **Company** that was issued under the **Group Short Term Accident Disability Insurance Policy**. This contract of coverage consists solely of (i) this written **Certificate** of coverage, (ii) the application for coverage of each **Insured**, which application is attached hereto and by this reference incorporated for all purposes, and (iii) any riders, endorsements or amendments attached hereto.

"Certificate Schedule" means the schedule of **Certificate** information that commences on page 3 of this **Certificate**.

"Class" means the classification by **Us** of (i) individuals to whom **We** have issued new coverage for the purposes of the calculation of their **Initial Premium** rates; and (ii) individuals to whom **We** have previously issued coverage for purposes of the calculation of their **Renewal Premium** rates.

"Company" means Freedom Life Insurance Company of America.

"Complications of Pregnancy" means:

1. conditions (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and
2. non-elective emergency cesarean sections, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, **Provider** prescribed rest during the period of pregnancy, morning sickness, and hyperemesis gravidarum. Nor does it include pre-eclampsia and similar conditions associated with the management of a difficult pregnancy unless such condition constitutes a nosologically distinct complication.

[**"Confinement"** or **"Confined"** means a **Medically Necessary Inpatient** admission of an **Insured** to a **Hospital** as a resident bed patient for not less than eight (8) hours, and for which **Inpatien**t **Confinement** the **Hospital** charges the **Insured** for at least one day of room and board expense. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.]

"Dispute" means any action, complaint, claim or controversy of any kind, (except those concerning **Utilization Review**), whether in contract or in tort, statutory or common law, legal or equitable or otherwise, now existing or hereafter occurring between the **Company** or any agent, employee, representative, heir, assign, beneficiary, successor, or affiliate of the **Company** and any **Insured** or any agent, representative, heir, assign, beneficiary, or successor of such **Insured**, in any way arising out of or pertaining to, or in connection with this **Certificate** or the **Group Policy** and any riders, endorsements, or amendments attached hereto, or any representation, modification, extension, interpretation, violation, renewal, reformation or rescission of this **Certificate**, and all related documents including, without limitation, advertising brochures, outlines of coverage, applications, correspondence and similar documents or any past, present or future incidents, omissions, acts, errors, claims handling, claims

procedures, practices or occurrences causing any alleged injury or damage to any party whereby the other parties or their agents, employees or representatives may be liable, in whole or in part.

[**"Elimination Period"** means the number of consecutive calendar days of an **Insured's Total Disability** as a **r**esult of an **Injury** that must occur before any applicable **Monthly Total Disability Benefit** is payable.]

"Family" means the spouse, son or daughter, brother or sister, parent, grandparent or grandchild of an **Insured**.

[**"First Certificate Year"** means for the period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.]

"First Renewal Date" means the first premium due date following payment of the **Initial Premium** which is shown on the **Certificate Schedule**.

"First Renewal Premium" means the amount of **Renewal Premium** due on the **First Renewal Date**. The amount of **First Renewal Premium**, if known on the **Issue Date**, is shown on the **Certificate Schedule**.

"Group Short Term Accident Disability Income Insurance Policy" means the association group insurance contract issued to the **Group Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

"Group Policyholder" means the association shown on the **Certificate Schedule** to whom the **Group Policy** was issued.

"Hospital" means a place which:

1. is legally operated for the care and treatment of sick and injured persons at their expense;
2. is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to it on a formal pre-arranged basis);
3. has continuous twenty-four (24) hour nursing services by or under the supervision of a registered nurse (R.N.); and
4. has a staff of one or more **Providers** available at all times.

It also means a place that may not meet the above requirements, but is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

"**Hospital**" does not mean:

1. a convalescent home, nursing home, rest home or **Skilled Nursing Home**;
2. a place primarily operated for treatment of **Mental and Emotional Disorders**, drug addicts, alcoholics, or the aged;
3. a special unit or wing of a **Hospital** used by or for any of the above;
4. a long-term mental care facility; or
5. a facility primarily providing Custodial Care.

"Initial Premium" means the amount premium charged for coverage under this **Certificate** for **You** together with all applicable coverage administration [and access fees], as well all applicable state and federal taxes for the period of time from the **Issue Date** through the day before the **First Renewal Date**. The amount of the **Initial Premium** is shown on the **Certificate Schedule**, and is payable in advance of the **Issue Date**

"Injury" and **"Injuries"** means damage or harm **Accidentally** sustained to the physical structure of the body of an **Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause, which occurs on or after the **Issue Date** and while coverage is in force and effect for such **Insured**. A specific **Injury** from which disability continues or recurs shall be considered one and the same **Injury** or "any one **Injury,**" unless periods of **Confinement** to a **Hospital** or service, treatment, or medical expenses incurred resulting from such **Injury** are separated by an interval of at least [thirty-ninety (30-90)] consecutive days between the end of one such period and the beginning of a subsequent such period.

"Inpatient" means an **Insured** who receives **Medically Necessary** services for an **Injury** or **Injuries** from a **Provider** in a **Hospital** when such **Insured** is **Confined** and receives room and board from such **Hospital** for not less than eight (8) hours. Treatment or services rendered or provided in a **Hospital** emergency room for an **Injury** or **Injuries** is not an **Inpatient Confinement** for the purposes of this **Certificate**. A period of **Inpatient Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

"Insured" means the **Primary Insured** whose coverage is in force and effect.

"Issue Date" means the date on which coverage under this **Certificate** commences for **You**. This date is shown on the **Certificate Schedule**.

"Maximum Period Payable for each Period of Total Disability" means the maximum number of months for which **Benefits** are payable under this **Certificate** and its riders, if any, for any one **Period of Total Disability.** The **Maximum Period Payable for each Period of Total Disability** is shown on the **Certificate Schedule.**

"Mental and Emotional Disorders" means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

"Mode Of Premium Payment" means the interval of time (monthly, quarterly, semi-annually or annually) that {*Option 1* [**You**]} {*Option 2* [the **Group Policyholde**r on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for each **Insured's** membership in the **Group Policyholder**]} [has/have] selected for payment of the **Initial Premium** and **Renewal Premium**. The premium payment interval selected as the **Mode Of Premium Payment** is shown on the **Certificate Schedule**. This **Mode Of Premium Payment** is subject to change at **Our** discretion.

"Monthly Total Disability Benefit" means the amount that **We** will pay for any full month of **Total Disability**. The **Monthly Total Disability Benefit** will be the lesser of: (1) the maximum monthly **Benefit** shown in the **Certificate Schedule**; or (2) [60%] **Your Prior Monthly Income**.

"Our" means Freedom Life Insurance Company of America.

"Period of Total Disability" means the period of time during which you are **Totally Disabled.**

["Premium Rate Guarantee Period" means the number of months immediately following the Issue Date that must expire before the amount of Renewal Premium charged by Us (with the same Mode Of Premium Payment as the Mode Of Premium Payment selected for payment of the Initial Premium) can be higher than the amount of the Initial Premium because of (i) a change by Us in the table of premium rates used to calculate the Initial Premium, or (ii) an increase in the attained age after the Issue Date of any Insured listed on the Certificate Schedule. However, the amount of Renewal Premium required for this Certificate may be increased by Us, even during the Premium Rate Guarantee Period, if after the Issue Date:

1. **You** change any other coverage option;
2. **You** change residence to a different ZIP code;
3. **You** change the **Mode Of Premium Payment**;
4. **You** add optional coverage riders, if any;
5. a change occurs in the **Benefits** by amendatory endorsement pursuant to any federal or state law or regulation.]

[The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**.]

"Primary Insured" means the individual whose name is printed on the **Certificate Schedule** as the **Primary Insured** and whose coverage under the **Certificate** has not ended.

"Prior Monthly Income" means **Your** [average monthly income] [earned income from occupation] over the last twelve (12) months or the last **Calendar Year**, whichever is greater.

"Provider" means a person who has successfully completed the prescribed course of studies in medicine at a medical school officially recognized and accredited in the country in which it is located, and which person has been licensed by the state in which the medical services are rendered to practice medicine. The **Provider** must be

acting within the scope of such license while rendering medically necessary professional service to an **Insured**, and cannot be a member of the **Insured's Family**.

"Renewal Premium" means the amount premium charged for coverage of all **Insureds** under this **Group Short Term Accident Disability Income Insurance Policy**, together with all applicable coverage administration as well all applicable state and federal taxes for the period of time from the **First Renewal Date** through the day before each subsequent renewal coverage renewal date. **Renewal Premium** for each renewal period is payable in advance for each applicable renewal period.

[**"Sickness"** means illness or disease, including, **Complications of Pregnancy,** afflicting an **Insured**, which first manifests itself on or after the **Issue Date** shown on the **Certificate Schedule** and while this **Group Short Term Accident Disability Income Insurance Policy** is in force and effect for such **Insured**.]

"Skilled Nursing Home" means a place which:

1. charges patients for their services;
2. is legally operated in the state (or similar jurisdiction) in which it is located;
3. has beds for patients who need medical and skilled care;
4. operates under a doctor's supervision;
5. has continuous twenty-four (24) hour nursing service supervised by a registered nurse (R.N.); and
6. keeps complete medical records on each patient.

"**Skilled Nursing Home**" also means a wing, area or floor of a **Hospital** specifically set aside to provide care similar to that of a **Skilled Nursing Home**, but it does not mean a **Hospital**.

"Short Term Accident Disability Income Benefit" means the coverage specifically set forth in the **Certificate Schedule**, and otherwise described in Section V. SHORT TERM ACCIDENT DISABILITY INCOME BENEFIT.

[**"Subsequent Certificate Year(s)"** means each twelve (12) month period ending on each anniversary of the **Issue Date** following the **First Certificate Year**.]

"Termination of Coverage" means Section III. C. TERMINATION OF COVERAGE, that governs the conditions and circumstances under which coverage may be terminated.

"Total Disability" or **"Totally Disabled"** means that due to **Injury**, **You** are:

1. under a **Provider's** care, **You** have reached maximum point of recovery and are still disabled under the terms of the contract. The **Company** reserves the right to periodically examine or cause to have examined **You** at **Your** own expense according to the terms of the contract[.][,] [and]

[2. unable to engage in any employment or occupation for which **You** are qualified by reason of education, training or experience and are not in fact **Actively at Work**, as certified by a **Provider** upon our request.]

"Us" means Freedom Life Insurance Company of America.

"We" means Freedom Life Insurance Company of America.

"You," "Your" means the individual listed on the **Certificate Schedule** as the **Primary Insured**.

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

This **Certificate** is effective at 12:01 A.M. local time where **You** live on the **Issue Date** shown on the **Certificate Schedule**.

B. ELIGIBILITY

The coverage for a **Primary Insured** will be effective under this **Certificate** when **We** approve the written application for such coverage and accept payment of premium.

C. TERMINATION OF COVERAGE

An applicable **Insured's** coverage ends on the earlier of the following:

a. the due date of any unpaid **Renewal Premium**, subject to the grace period; or
b. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in the application for **Your** coverage under the **Certificate** or in a claim for **Benefits**; or
c. the date **You** terminate coverage by notifying **Us** of the date **You** desire coverage to terminate; or the premium due date in the month following **Your** attainment of age 68; or
d. the premium due date in the month following the date the **Certificate** is terminated in which case **You** will be given thirty-one (31) days prior written notice of the termination, mailed to **Your** last known address; or
e. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Group Short Term Accident Disability Income Insurance Policy** or a **Class** under the **Group Short Term Accident Disability Income Insurance Policy** ; or
f. **We** elect to discontinue offering short term accident-disability income coverage to all individuals in **Your** state who are covered under the same coverage form as this **Certificate**, in which case **You** will be given a minimum of thirty-one (31 days prior written notice of the termination, mailed to **Your** last known address.

Any termination of coverage will be effective at 11:59 P.M. local time where **You** live on the date(s) specified above.

If premiums are accepted in error, **Our** liability is limited to coverage for the period of time for which premiums were accepted in error.

Except for claims involving fraud or intentional misrepresentation of material fact, any termination will be without prejudice to any claim for **Short Term Accident Disability Income Benefit** incurred prior to the date of termination. If coverage is terminated, unearned premium will be computed pro-rata and any unearned premium will be refunded to **You**.

D. REINSTATEMENT

If the **Renewal Premium** is not paid before the grace period ends, later acceptance of premium by **Us** (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium. If **We** require an application that will be fully underwritten by **Us**, **You** will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with all back or past due premium permitted by applicable state law. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45^{th}) day after the date of the conditional receipt, unless **We** have previously notified **You**, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only a **Total Disability** occurring after the effective date of reinstatement, subject to the **Elimination Period**.

In all other respects **Your** rights and **Our** rights will remain the same subject to any provisions noted on or attached to the reinstated **Certificate**.

E. EXTENSION OF BENEFITS

If the **Group Short Term Accident Disability Income Insurance Policy** terminates while an **Insured** is **Totally Disabled**, **Monthly Total Disability Benefits** will be extended for services incurred by such **Insured** after the date of **Termination Of Coverage** under this **Certificate**. These extended **Monthly Total Disability**

Benefits are subject to the same terms that would have applied if the **Group Short Term Accident Disability Income Insurance Policy** had remained in force.

Extended **Monthly Total Disability Benefits** are payable for specified **Injury** that caused **Total Disability** of an **Insured** and while coverage under this **Certificate** for such **Insured** was in full force and effect and (ii) while the **Insured** remains **Totally Disabled** until the earlier of:

1. the day the **Total Disability** ends;
2. the date twelve (12) months after the date the **Group Short Term Accident Disability Income Insurance Policy** terminated; or
3. the day the person becomes covered under a replacement.

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable {*Option 1* [by **You**]} {*Option 2* by the **Group Policyholde**r on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for an **Insured's** membership in the **Group Policyholder**]} to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep **Your** coverage in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) the plan of coverage, benefits, riders, limitations, and exclusions; (ii) **Mode Of Premium Payment** selected on the application; (iii) distribution channels; (iv) administrative costs; (v) taxes; (vi) other economic factors; (vii) the health status, including the results of any required physical examination and laboratory test results; (viii) the discounted or preferred premium rate status of any **Insured**; (ix) **Your** zip code (either first 3 or first 5 digits); (x) the number, age, sex and tobacco use of each **Insured** listed on the **Certificate Schedule**; (xi) premium rate ups, if any, for an **Insured**; and/or (xii) other coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar attained factors described above.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable {*Option 1* [by **You**]} {*Option 2* by the **Group Policyholder** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for an **Insured's** membership in the **Group Policyholder**]} on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid {*Option 1* [by **You**]} {*Option 2* by the **Group Policyholde**r on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for an **Insured's** membership in the **Group Policyholder**]} on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage will terminate.

Renewal Premium rates may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

a. **You** add **Insureds** to this **Certificate**;
b. **You** change residence to a different ZIP code;
c. **You** change any other coverage option;
d. **You** change the **Mode Of Premium Payment**;
e. **You** add optional coverage riders, if any;
f. a change occurs in **Group Short Term Accident Disability Income Insurance Policy** coverage, fixed indemnity benefits, limitations, exclusions, premium or other material matter; [and/or]

g. any change in coverage, fixed indemnity benefits, limitations, exclusions, or premium is required pursuant to any federal or state law or regulation[;][.]

We will notify **You** [and the **Group Policyholder**] in writing at least [thirty-one (31)-(forty-five (45)] days before any such **Renewal Premium** increase is due.

In addition, the amount of **Renewal Premium** may be increased by **Us** for any renewal period based upon items a. through e. above as well as the following:

a. change by **Us** in the table of premium rates used to calculate the **First Renewal Premium**; and
b. change by **Us** in the table of premium rates used to calculate **Renewal Premium** for any prior renewal period.

We will notify **You** [and the **Group Policyholder**] in writing at least [thirty-one (31)-(forty-five (45)] days before any increase:

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis. **We** will tell **You** [and the **Group Policyholder**] at least [thirty-one (31)] days in advance of the effective date of any **Renewal Premium** increase that occurs due to a change in the table of premium rates for **Renewal Premium**.

2. **RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED**

Any [premium payment made {*Option 1* [by **You** to **Us**]} {*Option 2* [by the **Group Policyholder** to **Us** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for an **Insured's** membership in the **Group Policyholder**]} by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. **GRACE PERIOD**

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew **Your Certificate** of coverage under the **Group Short Term Accident Disability Income Insurance Policy**, a grace period of thirty-one (31) days from such due date is given for the late payment {*Option 1* [by **You** to **Us**]} {*Option 2* [by the **Group Policyholder** to **Us** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for an **Insured's** membership in the **Group Policyholder**]} of the **Renewal Premium** due. If {*Option 1* [**You**]} {*Option 2* [the **Group Policyholder** on **Your** behalf]} make[s] payment to **Us** of the required **Renewal Premium** during such grace period {*Option* 2 [from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for an **Insured's** membership in the **Group Policyholder**]}, then coverage will remain in force for accident disability claims under this **Certificate** arising from **Monthly Total Disability Benefits Provided** during such grace period. However, if the **Company** has received notification of **Your** intention to cancel **Your** coverage, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due but for such cancellation.

4. **REINSTATEMENT**

If the **Renewal Premium** is not paid {*Option 1* [by **You**]} {*Option 2* [by the **Group Policyholde**r on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for each **Insured's** membership in the **Group Policyholder**]} before the grace period ends, later acceptance of premium by **Us** (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium, together with all applicable administration and policy fees, as well as all applicable state and federal taxes. If **We** require an application from **You** that will be fully underwritten by **Us**, {*Option 1* [**You**]} {*Option 2* [**You** and the **Group Policyholder**]} will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with payment {*Option 1* [by **You**]} {*Option 2* by the **Group Policyholde**r on **Your** behalf on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Policyholder** for each **Insured's** membership in the **Group Policyholder**]} of all back or past due premium permitted by

applicable state law. Lacking such underwriting approval, this **Certificate** will be reinstated on the forty-fifth (45^{th}) day after the date of the conditional receipt, unless **We** have previously notified {*Option 1* [**You**]} {*Option 2* [**You** and the **Group Policyholder**]}, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only **Monthly Total Disability Benefits** that result from an **Injury** sustained after the date of reinstatement.

In all other respects **Your** rights and **Our** rights will remain the same subject to any provisions noted on or attached to the reinstated **Certificate**.

5. **[PREMIUM RATE GUARANTEE PERIOD**

The amount of **Renewal Premium** (with the same **Mode Of Premium Payment** as the **Mode Of Premium Payment** of the **Initial Premium**) is guaranteed not to exceed the amount of the **Initial Premium** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of any (i) change in the table of premium rates used to calculate the **Initial Premium**, or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date** (i) **You** either add or change coverage under this **Certificate** as provided in paragraphs a. through g. of the Calculation – Payment provision, or (ii) an amendatory endorsement is issued that changes any of the fixed indemnity pursuant to any federal or state law or regulation.]

V. SHORT TERM ACCIDENT DISABILITY INCOME BENEFIT

Subject to all applicable definitions, exclusions, limitations, **Short Term Accident Disability Income Benefit** maximums, [**Elimination Periods**] and other provisions contained in this **Certificate,** as well as any riders, endorsements, or amendments attached hereto, **We** will pay the **Monthly Total Disability Benefit** amounts shown in the **Certificate Schedule** for the following specified **Short Term Accident Disability Income Benefit** incurred and received by an **Insured** while coverage under this **Certificate** for such **Insured** was in full force and effect.

A. MONTHLY TOTAL DISABILITY BENEFITS

Monthly Total Disability Benefits are payable under this **Certificate** if **You** become **Totally Disabled** while **You** are **Insured** under this **Certificate** and are **Actively at Work**. **Your Monthly Total Disability Benefit** will begin on the first day following the **Elimination Period** shown in the **Certificate Schedule**. The **Total Disability** must commence within [30 days] of the **Injury** which caused **Your Total Disability**.

The amount that **We** will pay for any full month of **Total Disability** will be the lesser of:

1. the **Monthly Total Disability Benefit** shown in the **Certificate Schedule**; or
2. [60% of] **Your Prior Monthly Income**.

We will pay 1/30 of the **Monthly Total Disability Benefit** otherwise payable for each day of a **Period of Total Disability** that is less than a full month.

B. RECURRENT DISABILITY

After a **Period of Total Disability** for which **We** paid **Benefits** ends, if **You** become **Totally Disabled** again within twelve (12) months from the same or related cause, **We** will consider it a continuation of the prior **Period of Total Disability**. If **You** have been **Actively at Work** for more than twelve (12) consecutive months between those two (2) **Periods of Total Disability**, then **We** will consider it a new **Period of Total Disability**.

C. CONCURRENT DISABILITY

If **Total Disability** is caused by more than one (1) **Injury**, **We** will pay as if the **Total Disability** was caused by only one (1) **Injury**.

[D.FOREIGN TRAVEL

This **Certificate** pays up to three months benefits for any **Total Disability** sustained or continued outside the United States, Canada or Mexico. If the **Insured** remains **Totally Disabled** upon returning to any of these countries, benefits will resume up to the maximum benefit period, as long as the **Insured** is **Totally Disabled**.]

VI. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

A. NOTICE OF CLAIM

Written notice of claim must be received by **Us** within thirty (30) days of the date of each **Total Disability** or the date the applicable expense is incurred. If it is not reasonably possible for the notice of claim to be transmitted to **Us** so that it is received within such thirty (30) day period, then written notice of claim must be received by **Us** as soon thereafter as reasonably possible. **Our** current address for providing a written notice of claim is shown on Page 1. A written notice of claim should include the applicable **Insured's** name and the **Certificate** number.

B. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

When **We** receive timely written notice of claim, **We** will normally send **You** a claim form to be completed, signed and returned. The general purpose of the claim form is to provide **Us** with general background information about the nature of the claim, which information may be necessary in order to complete a proper proof of loss. If this claim form is not provided to **You** within fifteen (15) days of **Our** timely receipt of written notice of the claim, then **You** will not be required to later complete, sign and return the written claim form, but may be required to provide other information, including a written authorization for the release of medical records and information, which in each event is necessary either for **Our** investigation of the claim or otherwise as part of the completion of a proper proof of loss. **We** must receive information requested within the time limit stated in the Section VI. C. PROOFS OF LOSS immediately below.

C. PROOFS OF LOSS

Written proof of loss must be provided to **Us** within ninety (90) days after the date of the **Total Disability** or the date the applicable expense is incurred. If it was not reasonably possible for **You** to give **Us** proof in the time required, **We** will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof of loss required must be provided no later than one (1) year from the date of the **Total Disability** or the date the applicable expense is incurred unless **You** are legally incompetent or otherwise physically unable to act.

D. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

As written notice of claims, completed claim forms, signed authorizations for release of medical authorizations, medical records, and other written information from **Insureds** and **Providers** are received and reviewed, additional investigation, requests for information and other matters may occur in connection with the completion of a proper proof of loss, adjustment and adjudication of the claim. At **Our** expense, **We** have the right to have the **Insured** examined by a **Provider** of **Our** choice as often as is reasonably necessary while a claim or other benefit determination is pending. Information received during the review and investigation of a claim will be considered, as applicable, in connection with whether a timely and proper proof of loss has been completed. After **Our** investigation has been completed, claims will be adjusted and adjudicated in accordance with the coverage that was in force on the date of the **Accident** or the date the applicable expense is incurred.

E. PAYMENT OF CLAIMS

Benefits will be paid to the **Primary Insured.** Any claim payment made by **Us** in good faith will fully discharge **Our** liability for such claim to the extent of the amount of such good faith payment.

F. TIME OF PAYMENT OF CLAIMS

We will make payments due promptly once a decision has been made on a claim and this decision has been processed.

Payment shall be treated as being made on the date a draft or valid instrument was placed in the United States mail to the last known address of the applicable **Primary Insured** in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

A **Benefit** payment owed by **Us**, but not paid within thirty (30) days after the date of **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim, will be considered past due. **We** will pay interest on any past due benefit payment amount at the rate of one and one-half percent per month commencing on the thirty-first (31st) day after the completion and **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim until the date such payment is tendered by **Us**.

VII. RIGHT OF INSPECTION

We may require information regarding pre-tax personal income, allowable business expenses, and other plans, including income tax returns, for periods before and after the start of a **Period of Total Disability**. Failure to provide such information may result in disqualification for **Benefit** payment under this **Certificate**.

VIII. COORDINATION WITH OTHER COMPENSATION

The **Monthly Total Disability Benefits** will be reduced by:

1. Disability benefits paid under any employee benefit plan or arrangement;
2. Income received from any employer paid sick pay plan, retirement plan or pension plan; and
3. Benefits to which **You** are entitled from Workers' Compensation or any other retirement program, including retirement benefits under the Federal Social Security program.

IX. EXCLUSIONS

No **Benefits** shall be payable under the **Certificate** for any loss caused by, in whole or in part, contributed to or resulting from, directly or indirectly, any of the following incidents, events, occurrences or activities involving any **Insured:**

1. **Injury** due to any act of war (whether declared or undeclared);
2. intentionally self-inflicted **Injury**;
3. suicide or any suicide attempt while sane or insane;
4. serving in one of the branches of the armed forces of any foreign country or any international authority;
5. an **Injury** occurring outside the borders of the United States of America or its territories except as provided in the FOREIGN TRAVEL BENEFIT provision of this Certificate;
6. any **Injury** while engaging, committing, or attempting to commit a felony or illegal occupation or while being arrested or incarcerated;
7. participation in hang gliding, paragliding, hot air ballooning or any other form of aviation, except as a fare-paying passenger traveling on a regularly scheduled commercial airline flight;
8. participating, as driver or passenger, in any competition, race or speed contest, including sanctioned practice thereof, of any land or water vehicle;
9. engaging in bungee jumping, parachuting, rock climbing, parasailing, Para kiting, surfing, mountaineering, skateboarding, or any other hazardous avocation;

10. participation in rodeo or equestrian events, semi-professional or professional sports or any other hazardous activity for wage, compensation, or profit;
11. participating in intercollegiate sports or club sports activities;
12. **Injuries** from raising, caring, handling or working with dangerous animals;
13. **Mental and Emotional Disorders**;
14. an **Insured** being intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a **Provider**, and taken in accordance with the limits of such advice. An **Insured** is conclusively determined to be intoxicated by drug or alcohol if: (i) a chemical test administered in the jurisdiction where either the **Accident** occurred or the **Insured** was medically treated is at or above the legal limit set by that jurisdiction; or (ii) the level of alcohol or drug was such that a person's coordination and/or ability to reason was impaired, regardless of the legal limit set by that jurisdiction;
15. **Sickness**;
16. the unintended or accidental results of any surgery or operation performed either for cosmetic purposes or in an attempt to surgically treat any **Sickness**;
17. the unintended or accidental result of any procedure, surgery or operation performed for cosmetic purpose or in an attempt to surgically treat any **Sickness**, or any elective procedures not medically necessary, including but not limited to organ donation and elective sterilization;
18. intentional inhalation or ingestion of any poison, gas or fumes;
19. the operation by an **Insured** of any motor vehicle without the permission/consent of the owner of such vehicle;
20. the operation by an **Insured** of any motor vehicle without a valid operator's license/permit;
21. bacterial or viral infection, except such infection occurring with or through a cut or wound in the skin sustained in an **Accident** or the accidental ingestion of contaminated material;
22. participating as a driver or passenger on a motorcycle, or an off-road or ATV vehicle;
23. actively serving in any armed forces, including National Guard or Army Reserves; and
24. **Injuries** from being arrested or incarcerated or caused while incarcerated in penal institution or government detention facility.

X. UNIFORM PROVISIONS

A. ENTIRE CONTRACT-CHANGES

The entire contract between **You** and the **Company** consists of the **Certificate**, **Your** application for coverage, which is attached to this **Certificate**, and any amendments, riders, or endorsements to the **Certificate**. All statements made by **You** will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to contest the insurance or reduce the **Short Term Accident Disability Income Benefit** unless contained in a written application, which is signed by the applicant. No agent may:

1. change, alter or modify the **Certificate**, or any amendments, riders, or endorsements attached thereto;
2. waive any provisions of the **Certificate**, or any amendments, riders, or endorsements attached thereto;
3. extend the time period for payment of premiums; or
4. waive any of the **Company's** rights or requirements.

No change in the **Certificate** will be valid unless it is:

1. noted on or attached to the **Certificate**;
2. signed by one of **Our** officers; and
3. notice of the change is delivered to the **Primary Insured**, as shown on the **Certificate Schedule**.

B. TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the **Issue Date**, only fraudulent misstatements in **Your** application may be used to void **Your** coverage under the **Certificate** or deny any claim for a loss occurring after the two (2) year period.

C. OTHER INSURANCE WITH US

You may have coverage under only one Certificate providing short term accident-disability income coverage with **Us**. If through error, **We** issue coverage under more than one like Certificate to **You**, only one coverage chosen by **You** or **Your** estate, as the case may be, will stay in force. **We** will return the money **You** paid for the other coverage.

D. CONFORMITY WITH STATE STATUTES

Any provision of the **Certificate** which, on the **Issue Date** shown on the **Certificate Schedule**, is in conflict with the laws of the state in which **You** live on such **Issue Date**, is amended to conform to the minimum requirements of such laws.

E. MISSTATEMENT OF AGE OR OCCUPATION

If the age or occupation of an **Insured** has not been stated correctly, his or her correct age or occupation will be used to determine (i) the amount of insurance for which he or she is entitled; (ii) the effective date of termination of insurance; and (iii) any other rights or **Benefits** under the **Certificate**.

Premiums will be adjusted if too much or too little was paid due to the misstatement.

F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION

During the first two (2) years an **Insured's** coverage is in force, it may be modified as provided below if, within that time, **We** discover that a medical condition or other material information was mistakenly not disclosed to **Us**:

1. The **Insured's** coverage will stay in force with no change in **Short Term Accident Disability Income Benefit** or premiums if the disclosure of such condition would not have affected the way the **Insured's** coverage was issued; or
2. If the disclosure would have resulted in coverage not being issued to an **Insured**, **We** will return all premiums paid, less any **Benefits** paid for that person during the time the coverage was in force in error. The coverage for that person shall be void from the **Issue Date**.

This Section does not apply to any fraudulent misrepresentations that are made, which in all events can result in rescission of any coverage issued as a result of such fraudulent misrepresentations.

G. LEGAL ACTION

No action at law or in equity will be brought to recover under the **Certificate** prior to the expiration of sixty (60) days after proof of loss has been filed as required by the **Certificate**; nor will any action be brought after three (3) years from the expiration of the time within which proof of loss is required by the **Certificate.**

H. PHYSICAL EXAMINATION

We will, at **Our** own expense, have the right and opportunity to examine **You** when **Your Total Disability** is the basis of a claim when and as often as **We** may reasonably require during the pendency of a claim and to make an autopsy in case of death, unless prohibited by law.

I. CHANGE OF OCCUPATION

If **You** become **Totally Disabled** after changing **Your** occupation to one classified by **Us** as more hazardous that that stated in **Your** application or while doing for compensation anything pertaining to **Your** classified occupation, all **Benefits** payable are those which the premium paid would have purchased for the more

hazardous occupation. If **You** change **Your** occupation to one classified by **Us** as less hazardous than that stated in **Your** application, **We** will reduce the premium rate accordingly, upon receipt of proof of change of occupation, and will return the excess pro-rata unearned premium from the date of change of occupation or from the premium due date immediately preceding receipt of proof, whichever is more recent. In applying this provision, the classification or occupational risk and the premium rates shall be such as have been implemented by **Us** prior to the occurrence of the loss for which **We** are liable or prior to the date of proof of change in occupation with the state official having supervision of insurance in the state where **You** resided at the time this **Certificate** was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by **Us** in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

J. CHANGE OF RESIDENCE

If **You** move, **You** must notify the **Company**. Only the extraterritorial benefits mandated by the state in which **You** reside, which are applicable to this type of coverage, will be considered **Benefits** under this **Certificate**. An **Insured** must be a permanent resident of the United States in order to remain eligible for insurance under this **Certificate**.

THIS CONCLUDES THIS CERTIFICATE

SERFF Tracking Number:	*USHG-127096386*	*State:*	*Arkansas*
Filing Company:	*Freedom Life Insurance Company of America*	*State Tracking Number:*	*48334*
Company Tracking Number:	*ACCDIS-2011-C-NOARB-FLIC*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.002 Short Term*
Product Name:	*ACCDIS-2011-C-NOARB-FLIC*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/29/2011

Comments:
See attached flesch certification.
Attachment:
NO ARB FLESCH ACCDIS.flic.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	03/29/2011
Bypass Reason:	See cover letter.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover letter	Approved-Closed	03/29/2011

Comments:
Attachment:
FLIC cover letter ACCCYD.pdf

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

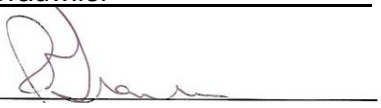
3100 Burnett Plaza • 801 Cherry Street • Unit 33 •Fort Worth, Texas 76102 • (800) 387-9027

READABILITY CERTIFICATION

I hereby certify that the forms, listed below, have been properly scored and have achieved the Flesch Score, as indicated.

Form Number	Flesch Score
ACCDIS-2011-C-NOARB-FLIC	44.25

Name: Ranita Grauwiler

Signature: 

Title: Vice President – Product Development

Dated: March 21, 2011

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza • 801 Cherry Street • Unit 33 •Fort Worth, Texas 76102 • (800) 387-9027

March 24, 2011

The Honorable Jay Bradford
Life and Health Division
Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904

Attn: Life & Health Section

RE: **Freedom Life Insurance Company of America**
FEIN # 61-1096685 NAIC # 62324

ACCDIS-2011-C-NOARB-FLIC Association Group Short Term
Accident Disability Income Certificate

Dear Commissioner Bradford:

Enclosed is the referenced form is filed for your review and approval. This form is new and is not intended to replace any forms previously filed with your Department. This form will be marketed using application form APP-FI-FLIC, et al and/or APP-09-NOARB-FLIC, previously approved by your Department on October 18, 2006 and May 18, 2009, respectively. Previously filed optional riders and amendatory endorsements may be issued with this certificate to provide additional benefits or meet regulatory requirements.

The certificate is an Association Group Short Term Accident Disability Income Certificate that provides benefits for Monthly Total Disability Benefits if the Insured becomes Totally Disabled while Insured under this Certificate and are Actively at Work, subject to the provisions and limitations set forth therein.

Please note that throughout the certificate, references to *{Option 1* and *{Option 2* denote two different options that the policyholder can choose from with regard to a specific subject. The terms *{Option 1* and *{Option 2* are shown for clarification only and will not show in the issued certificate. Only the bracketed language following *{Option 1* or *{Option 2* will show in the actual issued certificate, depending on which option is chosen by the policyholder.

This product will be issued to any associations previously filed in your state or that will be filed in the future. The group policy will be issued in Arizona. A certificate of insurance will be issued to members of the association to evidence coverage under the group policy. Please be advised this product is not employer/employee based, and we are offering it to individuals. The product is fully underwritten on an individual basis. Please note, we realize this form is exempt from filing in your state, however we require your confirmation as the situs of the association to which the group policy will be issued.

All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law. Paragraphs and definitions may vary to the extent that such paragraphs and definitions may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefits be within the intent and framework of the particular provisions. Additionally, there will also be items that customarily vary according to the certificateholder's specific plan of insurance. The schedule pages of the certificate are variable to accommodate this information.

We also reserve the right to amend the referenced form to correct any minor typographical errors we may have neglected to find prior to submission, and to amend the language in order to clarify the intent within the confines of the law.

Enclosed, please find the applicable transmittals, certifications and filing fees, if any.

Your consideration of this filing is appreciated. Should you have any questions, please contact me as listed below.

Sincerely,

Tina L. Wright
Product Development
1-800-387-9027, ext 423
wrightt@ushealthgroup.com